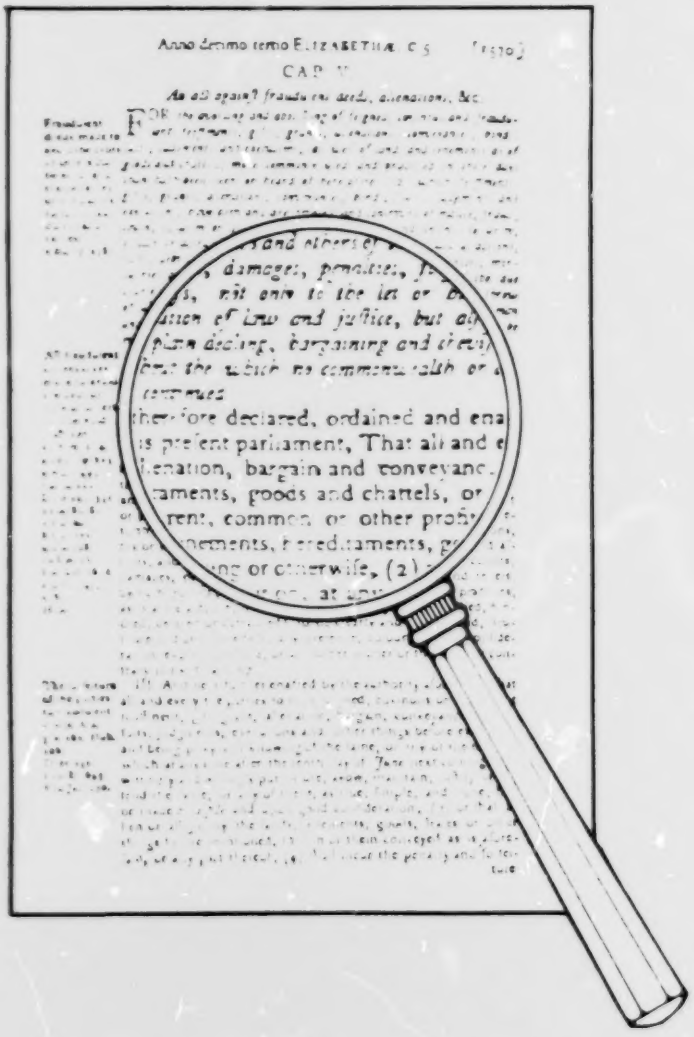
Law Reform
Commission of
Saskatchewan

Proposals for a Human Artificial Insemination Act

Report to the Minister of Justice

Saskatchewan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PROPOSALS FOR A HUMAN ARTIFICIAL INSEMINATION ACT

Law Reform Commission of Saskatchewan
Saskatoon, Saskatchewan

Report to the Minister of Justice

March, 1987

The Law Reform Commission of Saskatchewan was established by *An Act to Establish a Law Reform Commission*, proclaimed in November, 1973, and began functioning in February of 1974.

The Commissioners are:

Professor Douglas A. Schmeiser, Q.C., B.A., LL.B., LL.M., S.J.D., Chairman

Madam Justice Marjorie A. Gerwing of the Saskatchewan Court of Appeal

Mr. Gordon J. Kuski, Q.C., LL.B.

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Mr. Michael J.W. Finley, B.A., M.A., LL.B. is the Legal Research Officer, and Mr. Roderick J. Wood, LL.B., LL.M., Dip. in Legislative Drafting, Mrs. Sandy Antonini-Ready, B.A., LL.B. and Mrs. Myra J. Bucsis, LL.B. are Legal Research Officers under contract. The secretaries are Mrs. Sandra Ritchie and Miss Pat Harasymchuk.

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The Law Reform Commission Act

> 6. The commission shall take and keep under review all the law of the province, including statute law, common law and judicial decisions, with a view to its systematic development and reform, including the codification, elimination of anomalies, repeal of obsolete and unnecessary enactments, reduction in the number of separate enactments and generally simplification and modernization of the law.

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Saskatchewan

Law Reform
Commission of
Saskatchewan

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The Honourable Bob Andrew,
Minister of Justice,
Province of Saskatchewan,
REGINA, Saskatchewan.

Dear Mr. Minister:

The Commission has completed a study of the legal consequences of human artificial insemination.

Artificial insemination has become a common procedure in Saskatchewan in cases in which a married couple is unable to conceive in the ordinary manner because the husband is impotent or may transmit a genetic disorder to his biological children.

It is the involvement of a donor, usually anonymous and chosen by a physician, that creates the most pressing legal issues associated with artificial insemination. At present, the law provides no clear answer to questions about the legal position of the donor, the recipient's husband, and the child born as a result of artificial insemination. The report is designed to answer these legal uncertainties.

Pursuant to section 9 of The Law Reform Commission Act, the Commission submits this report recommending adoption of legislation governing human artificial insemination by a donor other than the recipient's husband.

Respectfully submitted this 10th day of March, A.D. 1987.

D.A. Schmeiser

Douglas A. Schmeiser, Q.C.,
Chairman.

Madam Justice Marjorie A. Gerwing,
Commissioner.

Gordon J. Kuski, Q.C.,
Commissioner.

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PROPOSALS FOR A HUMAN ARTIFICIAL INSEMINATION ACT

INTRODUCTION

Artificial insemination is becoming an increasingly common medical procedure in Saskatchewan. There is a growing acceptance of the procedure as a way of circumventing impediments which prevent conception in the conventional manner. At present, artificial insemination is primarily utilized in four types of situations. Most commonly, it is used when a male partner is azoospermic, oligozoospermic or asthenozoospermic: His body produces insufficient semen or abnormal semen, making fertilization impossible. These conditions may be inherited deficiencies, but are more likely to be a product of illness or vasectomy. Artificial insemination may also be recommended by a physician when both the male and female partners are carriers of a genetic condition which is recessive, and therefore hidden in each of them, but which may appear in their offspring. In other cases, an autosomal dominant genetic disorder may be carried by the male partner that may be passed to his offspring. Finally, artificial insemination may be indicated if the male partner has undergone chemical or radiation therapy that may have resulted in genetic damage.

Artificial insemination of a woman with the semen of her husband is occasionally performed in cases in which the husband is oligospermic. However, the semen used in artificial insemination is usually supplied by a donor other than the recipient's husband. It is artificial insemination by donor (A.I.D. or heterologous artificial insemination) which is the focus of this report. The social, legal and medical issues that are becoming more important as the utilization of artificial insemination increases are primarily associated with heterologous artificial insemination. In many respects, these issues are novel simply artificial insemination has not, until recently, been a matter which has attracted significant public recognition or concern. No common law rules have yet developed to deal with artificial insemination and no Canadian jurisdiction has adopted legislation to regulate its practice.

From a legal point of view, the most pressing problems created by the practice of artificial insemination result from the absence of rules defining the status of a child born as the result of A.I.D. Under what circumstances should the child be regarded as the legitimate child of the mother's husband? Should the child have rights of inheritance from the husband, and should the husband be responsible for maintenance of the child? What is the status of the donor of the semen? To what extent should the identity of donors be protected as a private matter between the donor and the physician who performs the insemination? None of these questions can be satisfactorily answered under the law as it stands at present. Physicians who perform artificial insemination often require their patients to obtain legal advice and complete a consent form reciting that the patient and her husband understand the legal consequences of artificial insemination. Unfortunately, a lawyer giving advice to a patient and her husband will not be able to ensure them that the child's status will be clear in law.

It is unlikely that the common law will be able to evolve a satisfactory approach to the question of the status of a child born as the result of A.I.D. without legislative intervention. The common law develops by analogy. Judges adapt law made in judicial decisions to new situations sharing common characteristics with issues that have previously come before the courts. But there is little background from which to draw guidance in adapting the law to deal with artificial insemination. It does not appear to be particularly helpful to adopt conclusions based on analogy to other types of human relationships, legal structures, or medical procedures. For example, if a married woman bears a child whose father is other than her husband, the child has no rights of inheritance from the mother's husband unless

the child is named in the husband's will. It should not follow, however, that a child born to a woman as a result of artificial insemination with semen other than that of her husband should never be treated as a child of her husband for inheritance purposes. Simply because there are children in Saskatchewan born as a result of A.I.D., legislation to regularize the status of those children is necessary.

In the Commission's opinion, other aspects of artificial insemination do not so urgently require legislative action. This is not to suggest that there is no controversy surrounding other aspects of artificial insemination. Because artificial insemination is a relatively new procedure, there is not yet a consensus within the medical profession about the standards to be followed when artificial insemination is performed. For reasons which will be set out below, however, the Commission has concluded that it would be inappropriate to now legislate standards. There is also a social and ethical dimension to artificial insemination that cannot be ignored. It cannot be said that there is a consensus of opinion in the community about the extent to which artificial insemination is desirable. In the Commission's opinion, however, it would be premature to attempt to judge these issues and recommend legislation that might straightjacket further discussion of artificial insemination.

The Commission's *Tentative Proposals for a Human Artificial Insemination Act* discussed the issues involved in artificial insemination more broadly than in this report. The Tentative Proposals were intending to generate awareness of the issues and facilitate discussion. However, as a practical matter, proposals for legislation regulating artificial insemination must begin with the fact that artificial insemination is presently being performed by physicians in Saskatchewan. It must address the legal questions raised by artificial insemination that the courts cannot be expected to resolve without the assistance of legislation. Legislation relating to other aspects of artificial insemination may be deemed desirable as both the legal system and society at large gain more experience with the procedure. The legislation recommended in this report would, if enacted, involve no more intervention in the practice of artificial insemination than appears necessary at present to protect the basic rights of the persons involved. It is intended as much as possible to avoid issues which involve value judgments or medical opinion.

I. PRE-INSEMINATION ISSUES

(a) The Selection of Donors

From a medical point of view, the critical and most time-consuming aspect of artificial insemination is the recruiting and screening of potential donors. The medical community has not yet established comprehensive guidelines for the investigation and screening of donors. It would appear that in practice there is a considerable divergence of opinion as to the extent of donor screening. For example, in an article entitled "Current Practices of Artificial Insemination by Donor in the United States" records that:

> Most doctors (62%) used medical students or hospital residents. 10.5 percent used other university or graduate students, and 17.8% used both. The remaining 9.7% of doctors who selected their own donors obtained donors from military academies, husbands of obstetric patients, hospital personnel and friends of the physician. Consequently, donors are not a random sampling of the general population but are a select group with presumably above average health and intelligence. Beyond the use of the select donor pool, there is little

> further screening. Most respondents took family medical histories (96%), but this questioning was often merely asking a donor if any genetic diseases existed in his family or presenting him with a short checklist of common familial diseases. A number of doctors expected medical students and hospital residents to screen themselves before donating semen.[1]

All Saskatchewan physicians who expressed an opinion to the Commission about the screening of donors agreed that a medical history should be taken, and tests performed to ensure that the donor will not transmit venereal disease. Some were of the opinion that additional testing to screen out the possibility of the transmission of genetic disorders should be performed, while others were of the opinion that a review of the medical history of the donor provides a sufficient safeguard.

In the Commission's opinion, it would be undesirable to stipulate screening procedures in legislation. Medical practice changes over time, as information about procedures accumulates. Statutory enactment of screening procedures would interfere with the professional judgment exercised by physicians, and risk premature standardization of screening requirements. It can be expected that the medical profession will establish screening requirements as the practice of artificial insemination becomes more routine. Screening should be regulated by the requirements established by good medical practice. For example, the Royal College of Obstetricians and Gynecologists in England, has recommended the following donor selection procedures:

> Donor Selection:
>
> Recruitment of donors may be difficult in the initial stages (but is likely to get easier as time goes on). It is very important that an adequate supply of donors should be recruited before too many patients are taken on. Donors should be recruited by a medical member of the team involved in the A.I.D. service. They are best recruited by personal contacts, and open advertising should be avoided. They should satisfy the following criteria:
>
> 1. Reasonable intelligence.
> 2. No personal or family history of inheritable disorders, as obtained at interview.
> 3. No personal history of potentially transmissible infection (e.g. venereal disease or hepatitis).
> 4. An acceptable physical appearance.
> 5. Responsible attitude.
> 6. Good fertility, as evidenced by semen analysis ....

[1] Currie-Cohen, Luttrell and Shapiro, "Current Practice of Artificial Insemination by Donor in the United States," (1979), 300 New England Journal of Medicine, 585. In Saskatchewan, university students have been used on occasion.

> The donors should be told to report any symptoms of, or contact with, infectious diseases. They can with advantage be checked periodically by culture of semen samples for gonococci.
>
> Consideration should be given to limiting the number of pregnancies from any one donor (e.g. up to 20).[2]

As standards are established by the medical profession, established legal principles will become available for enforcement of the standards. Under the law of negligence, a physician is expected to meet a reasonable standard of care. This common law standard was expressed by Mr. Justice Schroeder of the Ontario Court of Appeal in *Crits and Crits* v. *Sylvester et al*, where he stated:

> Every medical practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. He is bound to exercise that degree of care. He is bound to exercise that degree of care and skill which could reasonably be expected of a normal, prudent practitioner of the same experience and standing, and if he holds himself out as a specialist, a higher degree of skill is required of him than one who does not profess to be so qualified by special training or ability.[3]

A physician practising artificial insemination, who is or who holds himself out to be a specialist in the field, is thus required to exercise the skill and care expected of such a specialist. Failure to do so will render him liable in a negligence action should injury result from that failure.

Application of the principles of medical negligence to cases involving artificial insemination may present some novel problems. For example, the present state of genetic science may make it difficult in some cases to establish a causal link between a failure to properly screen donors and the appearance of a birth defect in a child born as the result of A.I.D. Because negligence law is largely a product of judicial decisions rather than statute, it has the capacity to adapt to meet new circumstances. It is premature, in the Commission's view, to attempt to predict the statutory adjustments which may be required to adapt negligence law to meet the problems that may be created by artificial insemination. Only if the response of the courts proves to be inadequate as experience with artificial insemination accumulates should legislation regulating the application of negligence principles to artificial insemination be considered.

(b) Other Liabilities of Physicians

When a physician supplies medical services to a patient, a contract exists between the physician and the patient.[4] A physician providing medical services under contract is liable

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[2] Proceedings of the Fourth Study Group of the Royal College of Obstetricians and Gynaecologists in England, *Recommendations for Centres Planning to set up an A.I.D. Centre.* (October 26-27, 1976).

[3] (1956), 1 D.L.R. (2d) 502 at 508; affirmed [1956] S.C.R. 991.

[4] Although payment for most medical services is made by the Saskatchewan Medical Care Commission, the contractual relationship between physician and patient remains. In consideration for the agreement to provide services, the physician receives a right to compensation from the Commission.

to pay damages for failure to perform any express or implied term of the contract. A promise or representation made to an A.I.D. recipient may be viewed by the court as a term of the contract. For example, it is possible that a promise by a physician to choose a donor with similar characteristics to those of the recipient or her husband would place the physician under a contractual obligation to procure such a donor.

In the Commission's opinion, it is unnecessary to provide any special regulation for contractual liability arising out of a doctor-patient relationship when A.I.D. is performed. While the consequences of the contract may be unusual in a medical context, it should be left to physicians and their patients to determine their contractual obligations.[5]

The possible liability of the physician performing A.I.D. has been discussed above in the context of the relationship between the doctor and the recipient. The common law, however, recognizes a claim for compensation for injuries sustained by a child *en ventre sa mere* (literally, in its mother's womb), if the child is subsequently born alive. For example, damages have been awarded to a child for injuries in an automobile accident which occurred before she was born.[6] If normal embryonic development was impeded by injury to the uterus during artificial insemination, damages might be awarded to compensate for resulting birth defects. The injury to the developing embryo could be a foreseeable consequence of the negligence in such a case.

However, birth defects that can be attributed to artificial insemination are more apt to result from inadequate screening. Use of semen carrying an autosomal dominant genetic disorder or an infectious disease will predictably lead to the birth of a child with birth defects or disease. The legal considerations involved in such a case would be similar to those encountered in the "wrongful life" actions that have been launched in the United States in recent years. In *Gleitman* v. *Cosgrove*, for example, the court was asked to award damages to an infant plaintiff who alleged that his mother's doctors were negligent in failing to inform his mother of the possibility that her child would be born with birth defects. If she had been given this information, it was argued, she might have decided to have an abortion. The claim was dismissed, the court noting that:

> The infant plaintiff would have us measure the difference between his life with defects against the utter void of non-existence, but it is impossible to make such a determination. The court cannot weigh the value of life with impairments with the nonexistence of life itself.[7]

To date, no wrongful life suit has succeeded in the United States, and none has been pursued in Canada. Whether an action for wrongful life should be available raises questions which go beyond the scope of a review of artificial insemination law. While it is true that a child born with defects as a result of inadequate screening by a physician is the real victim of a physician's negligence, it would, in the Commission's opinion, be premature to establish a right of recovery in such cases unless and until there is evidence that adequate compensation will not be provided indirectly to the child through an action by the mother against the physician.

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[5] In its Tentative Proposals, the Commission discussed the possible application of *The Sale of Goods Act* and *Consumer Products Warranties Act* to A.I.D. The Commission is now satisfied that the possibility that those Acts would be applied to A.I.D. is too remote to require further consideration.

[6] *Duval* v. *Sequin* [1972] 2 O.R. 686 (Ont. H.C.).

[7] 227 A (2d) 689 (N.J.S.C.).

Finally, it has been suggested that the husband of an A.I.D. recipient may have a claim against a physician who performs artificial insemination if the husband has not consented to the procedure. If such a claim could be made at all, it would be based on the proposition that artificial insemination amounted to adultery. In some provinces, damages may still be claimed by a husband against a man who has committed adultery with his new wife. In Saskatchewan, however, actions for damages based on adultery have been abolished. But if artificial insemination with the husband's consent amounts to adultery, it would provide a husband with grounds for divorce, with the possibility that the physician would be named as co-respondent. There is some older authority that artificial insemination may amount to adultery.[8] However, that proposition is no longer generally accepted as a correct statement of the law.[9] While it might be desirable in principle to definitively settle the issue by legislation, it must be noted that divorce is a matter with the jurisdiction of the Parliament of Canada. Provincial legislation declaring that A.I.D. is not adultery would not affect the definition of adultery applicable under the *Divorce Act*.[10] Adultery may also be a relevant consideration in applications for maintenance under *The Deserted Spouses' and Children's Maintenance Act*[11], but in the Commission's opinion, a statement in provincial law that artificial insemination does not amount to adultery would not resolve the real issue.

II. THE STATUS OF A CHILD BORN AS A RESULT OF A.I.D.

(a) The Present State of the Law

Saskatchewan law accords a different status to a child born in wedlock than to a child whose parents are not married to one another. The father of a child born in wedlock has an obligation to maintain the child under *The Deserted Spouses' and Children's Maintenance Act*[12], *The Infants Act*[13] and the *Divorce Act*.[14] The child will inherit property through its father under *The Intestate Succession Act*[15] or by will. The obligations of the biological father to a child born out of wedlock are more limited. Maintenance for the child can be ordered under *The Deserted Spouses' and Children's Maintenance Act* only if the child's parents have cohabited.[16] Support may also be ordered, however, under *The Children of Unmarried Parents Act* if the respondent can be shown to be the father of the child.[17] A child born out of wedlock inherits from his natural father only if the father has acknowledged the child as his own, or was living with the mother at the time of the child's birth and accepted

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[8] *Orford* v. *Orford* (1921), 58 D.L.R. 251 (Ont. S.C.).

[9] *MacLennan* v. *MacLennan* [1958] S.C. 105 (Scotland).

[10] *The Divorce and Corollary Relief Act*, 1986, R.S.C. 1971, c. D-8.

[11] R.S.S. 1978, c. D-26.

[12] *Ibid.*

[13] R.S.S. 1978, c. I-9.

[14] *Supra*, note 9.

[15] R.S.S. 1978, c. I-13.

[16] *Supra*, note 10, s. 2(1)(a)(iii).

[17] R.S.S. 1978, c. C-8.

the child as his own.[18] Finally, a person who is not the biological parent of a child, may be ordered to provide maintenance under the *Divorce Act* for the child of a former spouse in certain circumstances.[19]

The scheme of rights and obligations outlined above was designed to deal with cases involving illegitimate children and step-parents. Artificial insemination was not considered when those rights and obligations were established. They presumably apply to children born as a result of A.I.D., but the consequences of a literal application of the relevant statutes to cases involving such children would have an almost random impact which cannot be regarded as satisfactory.

Biologically, a child born as a result of A.I.D. is a child of the donor. The donor may, therefore, be under an obligation to maintain the child under *The Children of Unmarried Parents Act*. Since the child will be illegitimate, it would not, however, inherit through the donor unless the donor acknowledges the child as his own.

Maintenance may be available, however, from the mother's husband on divorce. Under the 1968 *Divorce Act*, a spouse could be ordered to pay maintenance to a child of the other spouse if an *in loco parentis* relationship existed between the child and the spouse from whom maintenance was sought.[20] A person stands *in loco parentis* to a child if he has acted in such a way as to demonstrate an intention of placing himself in the position ordinarily occupied by a parent for provision of the child's maintenance.[21] That definition would appear to be broad enough to encompass a child born as a result of A.I.D. The new *Divorce Act* establishes a maintenance obligation on a non-parent who "stands in the place of a parent" of a child of the other spouse.[22] The maintenance obligation created by the new Act is somewhat broader than under the old Act because it no longer requires evidence of prior financial support as a condition precedent to granting maintenance.

(b) The Status of the Mother's Spouse: Proposal for Reform

It is difficult to justify excluding the husband from support obligations toward a child if he has consented to the insemination of his wife. The most direct way to address this problem would be to deem a child born as the result of A.I.D. to be the child of its mother's husband if he has consented to the procedure. This approach has been adopted or proposed in several jurisdictions. For example, legislation in Kansas provides:

> Any child or children heretofore or hereafter born as the result of heterologous artificial insemination shall be considered at law in all respects the same as a naturally conceived child of the husband and wife so requesting and consenting to the use of such technique.[23]

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[18] *The Intestate Succession Act*, *supra*, note 14, s. 17. A bequest may be given to an illegitimate child designated by name in a will. However, a bequest to "my children" will include an illegitimate child only if the criteria set out in the text are met. See *The Wills Act*, R.S.S. 1978, c. W-14, s. 33.

[19] *Supra*, note 10, s. 2.

[20] *The Divorce Act*, 1967-68, c. 24, s. 2.

[21] *Shtitz* v. *C.N.R.* [1927] 1 W.W.R. 193 (Sask. C.A.).

[22] *The Divorce and Corollary Relief Act*, s. 2(2), note 10.

[23] Stat. Kan. 1968, c. 23 - Domestic Relations, s. 23-128 and 23-129.

In New York state, it is enacted that:

> Any child born to a married woman by means of artificial insemination performed by persons duly authorized to practice medicine and with the consent in writing of the woman and her husband, shall be deemed to be the legitimate, natural child of the husband and his wife for all purposes.[24]

The Alberta Institute of Law Research and Reform has recommended:

> That if a married woman is artifically inseminated by semen all or part of which is donated by a man other than her husband,
>
> (i) that the donor not be in law the father of the child, and
>
> (ii) the husband be in law the father of the child if he consents to the artificial insemination but not otherwise.[25]

Adoption of a similar formula would resolve both the maintenance and inheritance issues. Further consideration should be given, however, to the nature of the consent required.

Technically, a consent must precede the act to which it applies or it is properly an acceptance rather than a consent. However, in the Commission's opinion, it would be desirable to give legal recognition to the relationship between a child born as a result of A.I.D. and the spouse's husband when a parent-child relationship has been established, even if no consent was provided by the husband before the insemination was performed. Consent to an insemination should, therefore, be valid for purposes of determining the status of the child whether it is given before or after the insemination.

The form which consent takes requires stricter regulation. It will be important in practice, if the status of a child born as a result of A.I.D. is in dispute, to ensure that clear evidence of the consent has been recorded. The Commission's Tentative Proposals did not recommend that the consent be in writing. The Commission has, however, reconsidered this issue. It is concluded that the legislation should require a written consent in order to avoid difficult evidentiary questions.

As an additional guard against attempts to fabricate evidence of consent, the Commission has concluded that a consent should be valid for the purpose of establishing a legal parent-child relationship between a child and the recipient's husband only when the insemination has been performed under medical supervision with the semen of an anonymous donor. Since the physician will obtain the semen for purposes of the insemination in such cases, the physician will be in a position to corroborate the fact of artificial insemination, and will almost invariably have discussed the insemination with both the recipient and her spouse.[26]

(c) The Status of the Donor: Proposal for Reform

When an artificial insemination is arranged under medical supervision, the physician usually locates the donor. The donor ordinarily has no contact with the recipient, and the

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[24] New York Domestic Relations Law, s. 73, 1974.

[25] Alberta Institute of Law Research and Reform, *Report #20 - Status of Children*, June 1976, at 93.

[26] If an insemination is performed without medical supervision, nothing will prevent the recipient spouse from voluntarily assuming an obligation toward the child, or initiating a step-parent adoption.

physician attempts to protect the anonymity of the donor. The donor is not expected to assume any obligation toward the child born as a result of A.I.D. Yet, under existing law, if the donor can be identified, he may be under a maintenance obligation to the child. In the Commission's opinion, an anonymous donor should have no obligation to the child. Moreover, the donor is not a party to any agreement between the recipient and her husband. He should be protected from liability whether or not a proper consent to the insemination has been obtained from the husband.

Different considerations may apply if the donor is not anonymous. It is possible that a man may agree with a woman to father her child by artificial insemination. Whether it is appropriate to treat him as the father of the child in such a situation depends on the circumstances of the case. Artificial insemination may be regarded by the parties as merely an alternative to ordinary conception for personal or medical reasons. In such a case, it might be appropriate to treat the donor as the father of the child. On the other hand, the donor may have been selected by the recipient in order to increase the probability that the chlid will have certain genetic characteristics deemed desirable by the mother. In such a case, it is difficult to distinguish between the selected donor and an anonymous donor. Nevertheless, the Commission has concluded that legislation regulating artificial insemination should apply only to inseminations performed using the semen of anonymous donors. Any other approach would create more uncertainty in individual cases than would be justified by an adoption of special rules for unusual circumstances.

RECOMMENDATION

(1) Any child born to a married woman by means of artificial insemination performed under the supervision of a physician using the semen of an anonymous donor and with the consent in writing of the woman and her husband, whether before or after the insemination is performed, shall be deemed to be the legitimate, natural child of the husband and his wife for all purposes.

(2) Where heterologous artificial insemination (A.I.D.) is performed under medical supervision using the semen of an anonymous donor, the donor of the semen shall not in law be the father of the child.

III. CONFIDENTIALITY

Confidentiality of medical records has a special significance in the context of artificial insemination. It is crucial that donors can be assured that their identity will not be disclosed. Fear of the legal and personal implications that could result if the donor's identity was disclosed may deter many potential donors. It is also important that donors should not be able to learn the identity of recipients of their semen or the children born as a result of its use. The mother and the child must be protected from interference in their lives by donors who may wish to assert parental rights.

Physicians in hospitals offering artificial insemination services in Saskatchewan have been successful in convincing donors and recipients that their identities will not be disclosed. However, the Regulations under *The Hospital Standards Act*[27] relating to confidentiality of

[27] R.S.S. 1978, c. H-10.

patients' records were not designed to protect the anonymity of donors and recipients. Further, there is no common law privilege with respect to such information. Accordingly, if a physician or a person in control of records pertaining to artificial insemination is subpoenaed to give evidence in legal proceedings, he may be required to divulge the name of the donor or the semen recipient.

The Commission is of the opinion that strict regulation of the use of information contained in the records of institutions or physicians involved in artificial insemination is desirable. In addition, the law of evidence should be modified to provide that evidence as to the identity of donors, recipients and children born as a result of A.I.D. be inadmissible in court proceedings or proceedings before any tribunal.

RECOMMENDATION:

(1) Disclosure of the identity of a donor, recipient, or child born as the result of artificial insemination performed by a physician using the semen of an anonymous donor should be prohibited.

(2) Medical records of artificial insemination should not be admissible in any judicial proceeding, except in an action brought by the recipient in which the history of the semen, or of the child born as a result of the insemination is relevant, but the identity of the donor should not be disclosed in such a case.

APPENDIX

An Act respecting heterologous Human Artificial Insemination by physicians

Short title

1. This Act may be cited as *The Human Artificial Insemination Act*.

Interpretation

2. In this Act:

(a) "artificial insemination" means the artificial insemination of a woman by a physician with the semen of a donor, or the semen of a donor mixed with the semen of another man;

(b) "donor" means a man who has provided his semen anonymously for use in artificial insemination;

(c) "physician" means a duly qualified medical practitioner on the Register of the College of Physicians and Surgeons of Saskatchewan;

(d) "recipient" means a woman who has been inseminated by means of artificial insemination.

Status of child

3. Where before or after the coming into force of this Act a married woman is artificially inseminated and the husband consents in writing to the insemination, whether before or after the insemination is performed, a child born as a result of the insemination is deemed to be for all purposes the child of the recipient's husband as though the child were the natural child of her husband born in lawful wedlock.

Status of donor

4. Where before or after the coming into force of this Act, a woman is artificially inseminated, the donor is for all purposes deemed not to be the father of the child born as a result of the insemination.

Confidentiality

5. (1) No person shall disclose the identity of a donor, recipient, or child born as the result of artificial insemination except as permitted by this section.

(2) Records of an artificial insemination containing information as to the identity of a donor, recipient, or child born as a result of the artificial insemination are not admissible in any judicial proceedings, and persons in charge or in possession of records pertaining to artificial insemination and persons involved in any aspect of artificial insemination are not competent to give evidence in any proceeding as to the identity of a donor, recipient, or child born as the result of artificial insemination.

(3) Nothing in this section renders evidence inadmissible to establish in any proceeding brought by a recipient or a child born as a result of artificial insemination, that the artificial insemination occurred, that particular semen was used to artificially inseminate her, or that a named child was born as a result of the insemination, so long as the identity of the donor is not thereby disclosed.

(4) Nothing in this section prohibits the disclosure of the identity of a donor, recipient, or child born as a result of artificial insemination to another physician or medical personnel acting under his direction for any valid medical purpose.

COMMENTARY

Section 2

For the purposes of the Act, artificial insemination has a restricted meaning. The Act applies only to an artificial insemination using the semen of an anonymous donor, and performed under the supervision of a physician. The Act provides rules to determine the status of children born as a result of artificial insemination performed under these circumstances, and to determine the legal relationship of the donor to this child.

Section 3

This section is applicable only where a married woman has been inseminated under medical supervision with the semen of an anonymous donor. Under the proposed Act, consent of the husband to insemination has an effect in law similar to that of an adoption. The child born as a result of the artificial insemination becomes the legitimate child of the recipient's husband.

It should be noted that the consent referred to in the section is valid for the purposes of the section only if the recipient and the person giving the consent were married at the time of the insemination, and continued to be husband and wife at the time the consent was given. The consent may be given, however, either before or after the insemination.

Section 4

This section applies to relieve an anonymous donor from obligations toward a child born as a result of artificial insemination.

Section 5

This section provides extensive protection of the privacy of donors, recipients and children born as a result of artificial insemination.

The confidentiality required by the section extends beyond that ordinarily required in a physician-patient relationship in two respects. First, the proposed legislation would make records pertaining artificial insemination inadmissible in evidence except to the extent that it may be necessary to prove the fact of artificial insemination with particular semen. For example, if a negligence action is brought against a physician based on an allegation that the physician failed to properly screen the donor, evidence that the insemination was performed and of the screening procedures used by the physician would be admissible. Second, physicians performing artificial insemination, and other persons involved in the insemination or in possession of records pertaining to insemination, are placed under a duty to keep information pertaining to insemination confidential for the benefit of the donor, recipient and child. The ordinary confidential relationship between a physician and patient would not extend to the donor or child.